

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **6696**  
Registrar's No. **22**

FILED MAR 8 1943

Registration District No. **164**

Primary Registration District No. **5598**

1. PLACE OF DEATH:

(a) County **Johnson**  
(b) City or town **Rural Columbus Twns.**  
(c) Name of hospital or institution: **/**

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **50 Yrs.** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Rowan R. Garnett**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **No.**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife **/** 6. (c) Age of husband or wife If alive **1980** years

7. Birth date of deceased **June 6, 1980** (Month) (Day) (Year)

8. AGE: Years **62** Months **7** Days **0** If less than one day hr. min.

9. Birthplace **Owen Co. Kentucky** (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **/**

12. Name **Andrew T. Garnett**

13. Birthplace **Kentucky** (City, town, or county) (State or foreign country)

14. Maiden name **Anna Margaret Hall**

15. Birthplace **Tennessee** (City, town, or county) (State or foreign country)

16. (a) Informant **Miss Charlene Garnett**

(b) Address **Odessa, Mo.**

17. (a) **Burial** (b) Date thereof **Feb 9, 1943** (Month) (Day) (Year)

(c) Place: burial or cremation **Odessa, Mo Cemetery**

18. (a) Signature of funeral director **L. O. Williams**

(b) Address **Odessa, Mo.**

19. (a) **Feb 16, 1943** (b) **Spola M. Williams** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Johnson**  
(c) City or town **Rural**

(d) Street No. **7 Mi. SE of Odessa** (If outside city or town limits, write "RURAL") (If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **/**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **6** year **1943** hour **4 P.M.** minute **/** M.

21. I hereby certify that I attended the deceased from **Feb. 6 - Feb. 6 - 1943** to **Feb. 6 - 1943**  
that I last saw him alive on **Feb. 6, 1943**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Apoplexy**

Due to **Hypertension**

Due to **Smoking**

Other conditions **/** (Include pregnancy within 3 months of death)

Major findings: Of operations **/**

Of autopsy **/**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **/**

(b) Date of occurrence **/**

(c) Where did injury occur? (City or town) (County) (State) **/**

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **/**

While at work? (Specify type of place) (e) Means of injury **/**

23. Signature **E. B. Miller** (M. D. or other) **/**

Address **Odessa, Mo.** Date signed **Feb 16, 1943**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer, No. 8,

District File Number

Date Filed 3-5-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

working under my personal supervision.

Signed

*George P. Husmer*

Licensed Embalmer No.

7541

P. O. Address

*Odessa Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.